FOR DWC USE ONLY
QME NO.:_____
INPUT DATE:_____
INPUT BY:_____

APPLICATION FOR APPOINTMENT AS QUALIFIED MEDICAL EVALUATOR

Administrative Director
Division of Workers' Compensation-Medical Unit
P.O. Box 71010
Oakland, CA 94612

BLOCK 1 (FOR ALL APPLICANTS) **PLEASE TYPE OR PRINT LEGIBLY**

Please list your primary location. DO NOT USE P.O. BOX. Additional locations may be added when your fee assessment is paid. You will be billed shortly after passing the QME test.

LAST NAME	FIRST NAME	MI	JR/SR

BUSINESS ADDRESS (WHERE QME EVALUATIONS WILL TAKE PLACE)	CITY	ZIP + 4

MAILING ADDRESS FOR CORRESPONDENCE, **IF DIFFERENT**	CITY	ZIP + 4

BUSINESS PHONE (AREA CODE) NUMBER	BUSINESS EMAIL (OPTIONAL)	CAL. PROFESSIONAL LICENSE NUMBER	EXPIRATION (MM/YY)	YEAR ENTERED PRACTICE

PROCEED TO BLOCK 2

BLOCK 2 (FOR ALL APPLICANTS) **IMPORTANT: BLOCK 2 must be fully completed before proceeding.**

PROFESSIONAL EDUCATION INDICATE DEGREE OBTAINED (e.g. M.D., D.O., D.C., Ph.D., Psy.D., Ed.D., etc.)

COLLEGE, UNIVERSITY OR MEDICAL SCHOOL

CITY	STATE	DATE OF DEGREE	DEGREE

SUBMIT SUPPORTING DOCUMENTATION and PROCEED TO APPROPRIATE BLOCK

IF M.D. or D.O., COMPLETE BLOCKS 3,6,7,8,9,10
IF D.C., COMPLETE BLOCKS 4,7,8,9,10
IF Ph.D., Psy.D. or Ed.D., COMPLETE BLOCKS 5,7,8,9,10
OTHER DEGREES, COMPLETE BLOCKS 7,8,9,10

BLOCK 3 (FOR M.D.'s AND D.O.'s ONLY) POSTGRADUATE TRAINING

NOTE: ***For M.D.'s or D.O.'s who are not board certified, state law requires successful completion of a residency training program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. Fellowships will not be accepted in lieu of accredited residency training. DO NOT ENTER "SEE RESUME".***

PGY 1 or INTERNSHIP: Hospital/Facility	Location (City/State)	Type	From	To

RESIDENCY: Hospital/Facility	Location (City/State)	Type	From	To

RESIDENCY: Hospital/Facility	Location (City/State)	Type	From	To

RESIDENCY: Hospital/Facility	Location (City/State)	Type	From	To

RESIDENCY: Hospital/Facility	Location (City/State)	Type	From	To

IMPORTANT: IF APPLICANT IS BOARD CERTIFIED, PLEASE PROVIDE COPY OF BOARD CERTIFICATE(S). OTHERWISE, PLEASE PROVIDE COPY OF CERTIFICATE(S) OF COMPLETION OF POSTGRADUATE TRAINING.

SUBMIT SUPPORTING DOCUMENTATION and PROCEED TO BOX 6

BLOCK 4 (FOR D.C.'s ONLY)

NOTE: APPLICANT MUST MEET <u>ONE</u> OF THE FOLLOWING REQUIREMENTS **YES** **NO**

1) I am certified in California workers' compensation evaluation by either a California professional chiropractic association or an accredited California college recognized by the Administrative Director (i.e. Industrial Disability Evaluation Certificate [min. 44 hrs.]). ☐ ☐

2) I have completed a chiropractic postgraduate specialty program of a minimum of 300 hours taught by a school or college recognized by the Administrative Director, the Board of Chiropractic Examiners and the Council on Chiropractic Education. ☐ ☐

SUBMIT SUPPORTING DOCUMENTATION and PROCEED TO BLOCK 7

BLOCK 5 (FOR Ph.D.'s, Psy.D.'s AND Ed.D.'s ONLY)

NOTE: APPLICANT MUST MEET <u>ONE</u> OF THE FOLLOWING REQUIREMENTS **YES** **NO**

1) I am board certified in clinical psychology by the American Board of Professional Psychology. ☐ ☐

2) I have a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology, from a university or professional school recognized by the Administrative Director and have not less than five years postdoctoral experience in the diagnosis and treatment of emotional and mental disorders. ☐ ☐

3) I have not less than five years postdoctoral experience in the diagnosis and treatment of emotional and mental disorders and I have served as an Agreed Medical Evaluator (AME) on eight or more occasions prior to January 1, 1990. *(Please provide documentation of 8 AMEs, i.e. AME cover letters, first page of the reports, or a sworn statement made under penalty of perjury.)* ☐ ☐

SUBMIT SUPPORTING DOCUMENTATION and PROCEED TO BLOCK 7

BLOCK 6 (FOR M.D.'s AND D.O.'s ONLY)

NOTE: APPLICANT MUST MEET <u>ONE</u> OF THE FOLLOWING REQUIREMENTS

	YES	NO
1) I am board certified in the specialty for which I am applying to become a QME by a board recognized by the Administrative Director and the Medical Board of California or the Osteopathic Medical Board of California.	☐	☐
2) I completed postgraduate training in the specialty at an institution recognized by the ACGME or the American Osteopathic Association.	☐	☐
3) I have qualifications that the Administrative Director and the Medical Board of California or the Osteopathic Medical Board of California both deem to be equivalent to board certification in a specialty. *(Please submit documentation from the Medical or Osteopathic Board.)*	☐	☐

SUBMIT SUPPORTING DOCUMENTATION and PROCEED TO BLOCK 7

BLOCK 7 (FOR ALL APPLICANTS)

NOTE: APPLICANT MUST MEET <u>ONE</u> OF THE FOLLOWING REQUIREMENTS

	TRUE	FALSE
1) I devote at least one-third of my total practice time to providing direct medical treatment (Direct Medical Treatment is that special phase of the physician-patient relationship during which the physician: (1) attempts to clinically diagnose and to alter or modify the expression of a non-industrial illness, injury or pathological condition; or (2) attempts to cure or relieve the effects of an industrial injury.)	☐	☐
2) I have served as an Agreed Medical Evaluator (AME) on eight (8) or more occasions in the 12 months prior to submitting this application. *(Submit documentation of 8 AMEs, i.e. AME cover letters, first page of reports or a sworn statement made under penalty of perjury.)*	☐	☐

SUBMIT DOCUMENTATION, IF REQUIRED, and PROCEED TO BLOCK 8

BLOCK 8 (FOR ALL APPLICANTS)

PLEASE INDICATE THE SPECIALTY(IES) FOR WHICH YOU ARE APPLYING TO DO QME EXAMS-USE ENCLOSED SPECIALTY CODE LIST

Professional practice specialty code	Professional practice specialty code	Professional practice specialty code

Reminder: For M.D.'s & D.O.'s, a copy of your board certification or documentation of completion of a training program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association must be submitted. Documentation of subspecialty training is not necessary.

SUBMIT SUPPORTING DOCUMENTATION and PROCEED TO BLOCK 9

BLOCK 9 (FOR ALL APPLICANTS, IF COURSE COMPLETED)

I have completed a disability evaluation report writing course approved by the Administrative Director.

Course:_____ **Date of Course:**_____

SUBMIT SUPPORTING DOCUMENTATION and PROCEED TO BLOCK 10

BLOCK 10 (FOR ALL APPLICANTS)

Affirmations: ***(Initialing each box affirms that you have read and agree to each of the statements. Do not initial if your statement is untrue. Attach an explanation on a separate piece of paper.)***

INITIAL EACH BOX

A. License Status and Convictions ***(Present and past)***

☐

My license to practice medicine is active and is neither restricted nor encumbered by suspension, interim suspension or probation. I certify that I have not been convicted of either a misdemeanor or felony related to my practice or a crime of moral turpitude. ***(Do not initial if your statement is untrue. Attach an explanation on a separate piece of paper.)***

B. License Status and Convictions ***(Future changes)***

☐

I agree to notify the Administrative Director if my license to practice medicine is placed on suspension, interim suspension, probation or is restricted by my licensing agency. I further agree to notify the Administrative Director if I am convicted of a misdemeanor or felony related to my practice or a crime of moral turpitude. I understand that the Administrative Director may deny my application or conditionally accept my application if my license is on probation with my licensing authority.

C. Referrals; Specified Financial Interests; Other Prohibited Activities

☐

I agree that I shall abide by all Administrative Director regulations. I will not refer patients to facilities in which I or my family members have a financial interest, except as permitted by law. I agree that I shall not offer, deliver, receive or accept any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred evaluation or consultation. I agree not to solicit to provide medical treatment to an injured employee for any injury for which I have done a QME evaluation.

I have not performed a QME evaluation prior to appointment as a QME by the Administrative Director.

I declare I spend five or more hours per week in direct medical treatment (or, for applicants under the AME, retired, or faculty status, in other specified activity) at each location I have listed as a "primary practice" location.

I have accurately and fully reported all specified financial interests that may affect the fairness of QME panels, as required on the attached QME SFI Form 124.

Verification

I have used all reasonable diligence in preparing and completing this application. I have reviewed this completed application and to the best of my knowledge the information contained herein and in the attached supporting documentation is true, correct and complete. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. *(Failure to provide truthful information shall result in denial of applicant's appointment and/or disciplinary action.)*

Executed on _____ **at** _____, **CA** _____

(MM/DD/YY) **County** **Applicant's Signature**

IMPORTANT: Your application for appointment as a QME shall be returned if it is incomplete. Please check:

1) That your application is fully completed, dated and signed with an original signature. We will not accept faxed applications. Please also submit the statement of citizenship form (QME Form 101).

2) All necessary documentation is attached:

   a) All applicants: A Copy of your current California Professional License.

   b) M.D.'s, D.O.'s: A copy of your board certification or certificate(s) of completion of a residency training program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. Please provide a copy for each specialty in which you are requesting appointment to perform QME exams.

   c) D.C.'s: A copy of your certificate in California Workers' Compensation Evaluation or a copy of your certificate from postgraduate specialty diplomate program.

   d) Ph.D.'s, Psy.D.'s and Ed.D.'s: A copy of your professional diploma(s). A copy of board certification, if appropriate.

   e) ALL OTHERS: A copy of your professional diploma(s) and California License.

   f) A copy of the completion certificate from the report writing course is required by Title 8 Cal. Code Regs. §11.5, once completed. **This document must be submitted prior to obtaining your appointment as a QME.**

   g) A completed, signed QME SFI Form 124. (QME Disclosure of Specified Financial Interests That May Affect the Fairness of QME Panels. **This document must be submitted prior to obtaining your appointment as a QME.**

A PUBLIC DOCUMENT

PRIVACY NOTICE - The Information Practices Act of 1977 and the Federal Privacy Act require the Administrative Director to provide the following notice to individuals who are asked by a governmental entity to supply information for appointment as a Qualified Medical Evaluator (QME).

The principal purpose for requesting information from QME's is to administer the QME program within the California workers' compensation system. Additional information may be requested if your application is denied and/or a disciplinary action is taken.

The California Labor Code requires every QME physician to meet certain statutory requirements. Physicians are required by the Labor Code to provide: name; business address/addresses; professional education; training; license number; year entered practice and other requirements deemed necessary by the Administrative Director. It is mandatory to furnish all the appropriate information requested by the Administrative Director. Failure to provide all of the requested information may result in the denial of the application.

As authorized by law, information furnished on this form may be given to: you, upon request; the public, pursuant to the Public Records Act; a governmental entity, when required by state or federal law; to any person, pursuant to a subpoena or court order or pursuant to any other exception in Civil Code § 1798.24.

An individual has a right of access to records containing his/her personal information that are maintained by the Administrative Director. An individual may also amend, correct, or dispute information in such personal records (Civil Code § 1798.34-1798.37).

Requests should be sent to:

Division of Workers' Compensation-Medical Unit
P.O. Box 71010
Oakland, CA 94612
Tel: (510) 286-3700 or (800) 794-6900
Fax: (510) 622-3467

You may request a copy of the Division of Workers' Compensation policy and procedures for inspection of records at the above address. Copies of the procedures and all records are ten cents ($0.10) per page, payable in advance. (Civil Code § 1798.33).

For Use on the QME Application Form 100

IMPORTANT: PLEASE USE THREE LETTER SPECIALTY CODE WHEN COMPLETING BLOCK 8 OF APPLICATION FORM

MD/DO SPECIALTY CODES

MAI	Allergy & Immunology
MPA	Anesthesiology - Pain Medicine
MDE	Dermatology
MAI	Dermatology - Allergy & Immunology
MEM	Emergency Medicine
MTT	Emergency Medicine - Toxicology
MFP	Family Practice
MPM	General Preventive Medicine
MPT	General Preventive Medicine – Toxicology
MMM	Internal Medicine
MAI	Internal Medicine - Allergy & Immunology
MMV	Internal Medicine - Cardiovascular Disease
MME	Internal Medicine – Endocrinology Diabetes & Metabolism
MMG	Internal Medicine - Gastroenterology
MMH	Internal Medicine - Hematology
MMI	Internal Medicine - Infectious Disease
MMO	Internal Medicine - Medical Oncology
MMN	Internal Medicine - Nephrology
MMP	Internal Medicine - Pulmonary Disease
MMR	Internal Medicine - Rheumatology
MPN	Neurology
MPA	Neurology - Pain Medicine
MNS	Neurological Surgery
MNB	Neurological Surgery – Spine
MOG	Obstetrics & Gynecology
MPO	Occupational Medicine
MTT	Occupational Medicine – Toxicology
MOP	Ophthalmology
MOS	Orthopaedic Surgery
MNB	Orthopaedic Surgery - Spine
MHH	Orthopaedic Surgery – Hand
MMO	Orthopaedic Surgery - Oncology
MTO	Otolaryngology
MPA	Pain Medicine
MHA	Pathology
MEP	Pediatrics
MAI	Pediatrics - Allergy & Immunology
MPR	Physical Medicine & Rehabilitation
MPA	Physical Medicine & Rehabilitation – Pain Medicine
MPS	Plastic Surgery
MHH	Plastic Surgery - Hand
MPD	Psychiatry
MMO	Radiology – Oncology
MSY	Surgery
MHH	Surgery - Hand
MSG	Surgery - General Vascular
MTS	Thoracic Surgery
MUU	Urology

NON-MD/DO SPECIALTY CODES

ACA	Acupuncture
DCH	Chiropractic
DEN	Dentistry
OPT	Optometry
POD	Podiatry
PSY	Psychology
PSN	Psychology - Clinical Neuropsychology